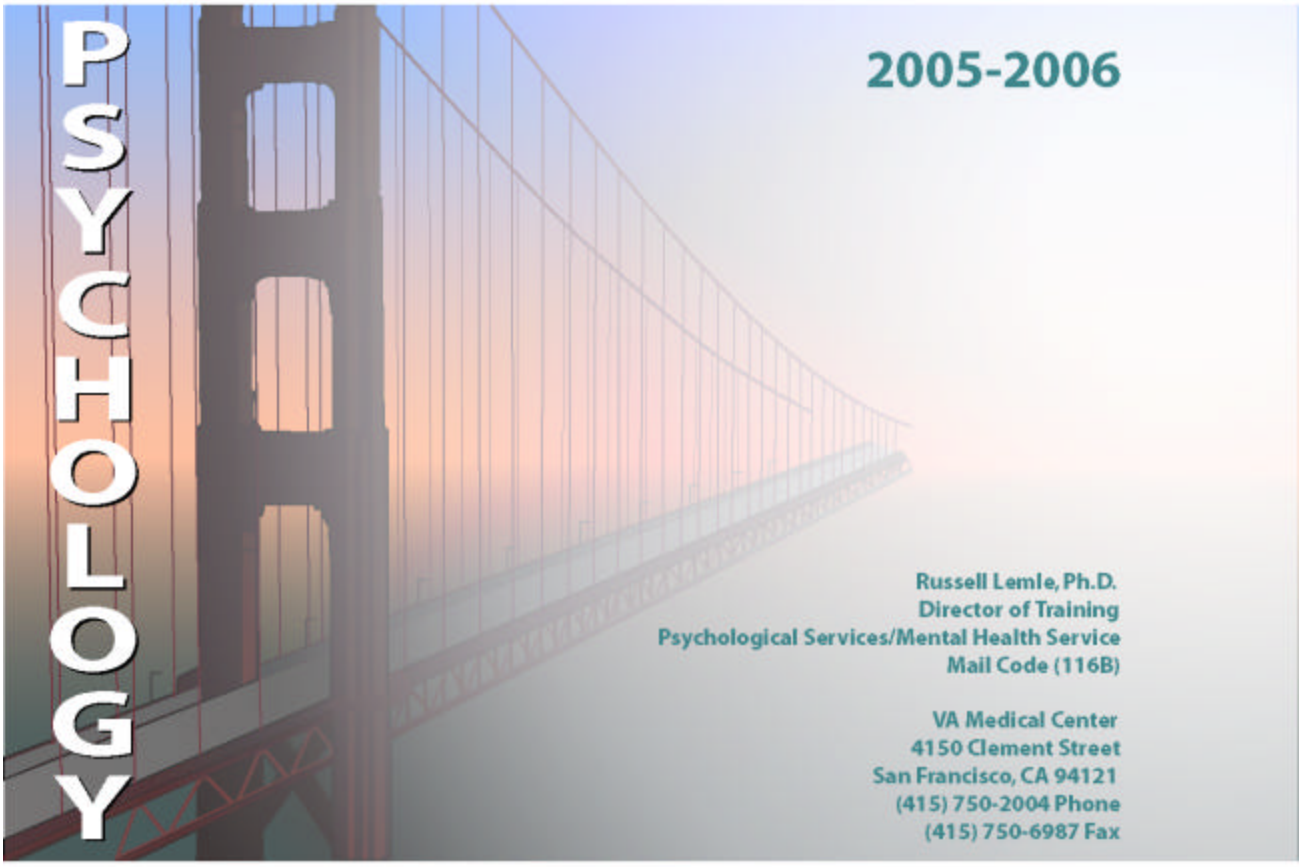
Postdoctoral Fellowship in Clinical Psychology with Emphasis in Posttraumatic Stress and Substance Abuse Disorders



2005-2006

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Post-Doctoral Clinical Psychology Fellowship Program
In Posttraumatic Stress and Substance Abuse Disorders

116B

Post-Doctoral Psychology Fellowship Applicant
San Francisco VA Medical Center

Dear Prospective Applicant:

Thank you for your interest in the **Post-Doctoral Clinical Psychology Fellowships** at the **San Francisco VA Medical Center**. The fellowship class for which you are applying will begin **September 1, 2005**. Two stipended slots will be available, at a rate of $40,000 annually. Federal health insurance coverage, holiday, sick and professional leave are provided.

The fellowships' areas of training emphasis are **posttraumatic stress and substance abuse disorders**. In both areas of emphasis, fellows will receive supervised experience in evaluation and assessment, psychological treatment, consultation, and interpersonal treatment planning. They will be given opportunity to develop team leadership and clinical supervision skills. Up to six hours weekly will be devoted to conducting research under an assigned mentor. Fellows will attend three required advanced seminars and can select from numerous other educational offerings. The fellowship will satisfy post-doctoral supervised hour requirements for California licensure. While both fellows will receive didactic and clinical training in both areas of emphasis, one position features a **Trauma Emphasis** and one position has an **Addiction Emphasis**. You are welcome to apply for both, but you should indicate on the appropriate portion of your application which position is your first preference. Candidates must have completed an APA-approved internship and an APA-approved doctoral program prior to start of fellowship. Application deadline is **January 28, 2005.**

Please download and review our fellowship brochure and fill out the downloaded application form. If you have any questions about the fellowship, please feel free to call me at (415) 221-4810 ext 2348 or e-mail me at russell.lemle@med.va.gov. SFVAMC is an Affirmative Action/Equal Opportunity Employer.

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POST-DOCTORAL CLINICAL PSYCHOLOGY FELLOWSHIP PROGRAM
EMPHASIS IN POSTTRAUMATIC STRESS AND SUBSTANCE ABUSE DISORDERS
San Francisco VA Medical Center

September 2005 – August 2006

BACKGROUND

In 2000, the San Francisco VA Medical Center (SFVAMC) Mental Health Service inaugurated a clinical post-doctoral psychology fellowship program in clincial psychology with emphasis in the areas of Substance Abuse and PTSD. The fellowship complements a growing amount of treatment, education and research in these areas over the past two decades. Since 1980, we have had an ongoing VA-sponsored Physician Fellowship in Substance Abuse, with 29 graduates to date. In 1998, the VA Sierra Pacific Network was awarded a Mental Illness Research, Education and Clinical Center (MIRECC), with the SFVAMC Posttraumatic Stress Disorder Clinical Treatment Team (PCT) a core component. The clinical, teaching and scholarly achievements of our faculty are extensive, and are delineated below in the description and appendixes. Within Substance Abuse and PTSD, psychologists hold key leadership roles, providing a rich opportunity for mentoring and role modeling of post-doctoral fellows.

Psychological services and psychology training at the SFVAMC are integrated within the Mental Health Service Product Line. The current psychology staff consists of 13 Ph.D. psychologists, all of whom hold academic appointments at the University of California, San Francisco (UCSF). The median length of staff's VA employment is 16 years. A Chief Psychologist oversees professional activities, e.g. training, credentialing and privileging, performance evaluations, and professional development.

The Mental Health Service teams where our psychologists and trainees are placed have an interdisciplinary structure with the following disciplines represented: psychology, psychiatry, social work, nursing, internal medicine, addiction specialist, and vocational rehabilitation. One of the cornerstones of our Psychology training model is to expose trainees to the unique contributions that other disciplines bring to mental health treatment.

Education of current and future health care providers is one of the five missions of the SFVAMC and has a major presence. Over 1500 fellows, residents, interns and students from a wide array of disciplines train here yearly. Mental Health Grand Rounds occur monthly. Unit based in-services are offered regularly. The SFVAMC Mental Health Service is affiliated with the Department of Psychiatry, UCSF Medical School, and as such, our staff and trainees have access to their library, colloquia and seminars including weekly Psychiatry Grand Rounds.

Psychology Training

The psychology pre-doctoral internship has been APA-accredited since 1979 with three full-time VA-funded pre-doctoral clinical positions. Our internship remains one of the most competitive in the country, with over a hundred applicants from top-rated psychology graduate programs annually.

Our service also trains advanced students from APA-approved psychology graduate programs. Yearly, we admit two post-doctoral clinical fellows and ten pre-doctoral externs who work 20-hours/week. We also have VA-funded summer interns. We hold a strong commitment to training future psychologists and devote substantial time and energy to this endeavor. Staff meet monthly to review the training program or trainees' progress. Full-time psychology interns receive a weekly average of four hours of individual supervision, often enhanced by videotaping, direct observation, or co-therapy with a senior clinician.

Post-doctoral Rotation Sites

(Please note: Descriptions of the PTSD and Substance Abuse Clinical Programs and on-going research are included in Appendixes C, D, & E).

1. *Posttraumatic Stress Disorder Clinical Team (PCT).* (Frank Schoenfeld, M.D. Director and Victoria Tichenor, Ph.D., Director of PTSD Training) The PCT, treats patients with chronic PTSD, often associated with co-morbid conditions and social dysfunction. There are five planned phases of treatment: evaluation, stabilization, exposure, integration/relapse prevention and maintenance, each with different form and intensity of intervention. The PCT is one of the preeminent clinical, educational and research-based programs treating veteran outpatients suffering from PTSD. It is an extremely fertile source of interprofessional collaboration and intellectual stimulation. The interprofessional PTSD team consists of psychologists, psychiatrists, social workers, nurses, post-doctoral psychology fellows, post-doctoral psychiatry fellows, psychiatry residents, and predoctoral psychology interns. Dr. Tichenor provides psychology clinical supervision on the team.

2. *Substance Use/PTSD Team (SUPT).* (John Straznickas, M.D., Team Leader, Psychologist being recruited). The SUPT Team, is one of nine specialized programs in the DVA system dedicated to treatment of outpatients with comorbid PTSD and Substance Abuse Disorders. The team consists of a psychiatrist, two social workers, a rehabilitation technician, predoctoral psychology and social work interns, psychiatry residents, and substance abuse physician fellows.

3. *Drug and Alcohol Treatment Team (DAT).* The Drug and Alcohol Treatment Team (DAT). (David Thomson, LCSW, Team Leader). The DAT Team is an abstinence oriented clinic treating patients with alcohol, cocaine, and polysubstance abuse problems. Psychosocial treatment is based on the Phase Model of treatment and includes supplemental interventions based on an integrative review of multiple assessments. The team consists of a psychologist, a psychiatrist, two social workers, two addiction therapists, predoctoral psychology interns, a post-doctoral psychology fellow, psychiatry residents, and a psychiatry fellow. Dr. Patrick Reilly provides clinical supervision on the team.

4. *Opioid Replacement Team (ORT).* (Scott Smolar, M.D., Team Leader, Yong Song, Ph.D., psychologist) The ORT Team, treats heroin addicts with opioid replacement medications (methadone). Many patients enrolling in methadone maintenance are initially stabilized in the Substance Abuse Day Hospital. All patients are involved in psychosocial treatment based on a Phase Model organized around levels of privileges and frequency of take-out doses. The team consists of a psychologist, a psychiatrist, a vocational rehabilitation specialist, four addiction therapists, predoctoral psychology interns, and a substance abuse psychiatry fellow. Dr. Song provides psychology clinical training on the team.

5. *Psychological and Neuropsychological Assessment Program* (PNAP), (Johannes Rothlind, Ph.D., Director) provides neuropsychological, intelligence, and other psychological assessment services to a) assist in diagnosis, b) provide documentation of baseline functioning and to monitor changes in cognitive functioning and psychological adjustment and c) aid in treatment planning. Other activities include consultation and brief individual and family interventions to assist in managing disability and psychological morbidity linked to the neurocognitive disorder. Median duration of each evaluation is 2.5 hours. The staff consists of one psychologist, one psychology technician, predoctoral psychology interns and psychology practicum students.

6. *Santa Rosa Clinic* Santa Rosa Community Based Outpatient Clinic, Mental Health Service (SR MHC). (Robert Nadol, M.D. Chief; Patrick Reilly, Ph.D., Associate Chief). The SR MHC is located 55 miles north of San Francisco and is a satellite clinic of the San Francisco VA. The SR MHC serves veteran patients predominately from Sonoma, Marin, Napa, Lake, and Mendocino Counties. The clinic provides high quality care for veterans with mental health problems, emphasizing chronic severe mental illness, combat- and sexual-assault related posttraumatic stress disorder, substance abuse, late life depression and dementia, mental health problems of homeless veterans, and psychiatric illness co-occurring with medical illnesses. The SR MHC consists of a multidisciplinary treatment team including four psychiatrists, two psychologists, two registered nurses, a social worker, a readjustment counselor, a postdoctoral psychology fellow, and two predoctoral psychology practicum students. Drs. Patrick Reilly and Stephen Pennington provide clinical supervision in the clinic.

7. *PTSD and SA Research*. The SFVAMC Mental Health Service currently has approximately six million dollars in current year grant funding. The PTSD Program has developed a research program over the past ten years that is recognized as one of the leading centers in the nation. Drs. Marmar and Weiss were co-principal investigators on the National Vietnam Veterans Readjustment Study of combat-related PTSD. The study persuaded the Department of Veterans Affairs to develop a nationwide initiative to provide specialized outpatient treatment for Vietnam. The PCT has seven major research projects in operation. Since November 1998, it has been a MIRECC core site. PTSD research now underway examines risk factors for acquiring PTSD and resiliency in preventing it, the nature of acute stress response in emergency services personnel, psychophysiological correlates of PTSD, and a manualized form of trauma focused group therapy.

The Substance Abuse Program also has had a history of prolific research productivity. Through the 1990's, we have served as the home of the San Francisco Treatment Research Center (TRC), one of eight national centers funded by NIDA to develop innovative drug abuse treatments. Psychologists have current VA and NIH funded grants studying the treatment of cocaine abuse, anger management, nicotine relapse prevention, combination treatments for smoking cessation, and psychosocial variables that predict drug abuse treatment outcome. More detailed descriptions of current PTSD and SA research are listed in Appendix E.

FELLOWSHIP PROGRAM DESCRIPTION

Emphasis/Purpose

This post-doctoral fellowship provides advanced interdisciplinary education and training, with emphasis in the areas of **posttraumatic stress and substance abuse disorders.** We subscribe to the scholar-practitioner model of psychology training. Post-doctoral fellows will receive advanced training with special emphasis in these two areas specifically relevant to working with veteran populations. The fellow will graduate competent to work as an advanced level psychologist within the Veterans Health Administration system or other entity in which the complementary areas of trauma and addiction are salient. Advanced training is defined by the following criteria:

1. Intensive **immersion** in clinical experiences in these two areas with supervision by licensed psychologists with established competencies in these areas.

2. **Didactic training** to provide a background and context in the empirical, clinical and other literatures relevant to these areas.

3. Greater **breadth of supervised experiences** than that received by predoctoral interns, including leadership and supervisory roles with staff and trainees on relevant clinical teams.

4. Opportunities for greater **depth of supervised clinical experiences** than is feasible for a psychology intern on the same rotation areas. Examples include exposure to a wider variety of patients, more complicated or challenging cases, or cases requiring specialized skill sets (e.g., EMDR, motivational interviewing techniques, specialized assessment procedures).

5. Opportunities to participate in **research activities** relevant to PTSD and Substance Abuse under the mentorship of psychologists involved in cutting-edge research in these areas.

6. An additional postdoctoral year of **general professional development**, including overall seasoning, being treated on a par with licensed psychologists and taking on and internalizing the role of mentoring other trainees.

Objectives

Upon completion of the program, each fellow will be able to demonstrate an advanced level of competence in the following seven areas: Evaluation and Assessment of PTSD or SA, Psychological Treatment of PTSD or SA, Psychological Consultation regarding PTSD or SA, Treatment Planning and Case Management in PTSD or SA, Research in PTSD or SA, Supervision and Leadership, and Role as a Professional Psychologist (see Appendix D, Psychology Trainee Evaluation Form).

Teaching Methods

Fellows will receive a weekly minimum of two hours of individual and one hour of joint clinical supervision from the psychology faculty. Methods of supervision include role modeling, mentoring, in-vivo observation, videotape review and co-therapy. Supervisors treat fellows as colleagues.

Fellows will have opportunities to work with patients of varying backgrounds, cultures, and clinical needs. We build upon baseline skills acquired during predoctoral internship. The fellow will be granted progressively more autonomy and responsibility over the course of the year in an organized sequence.

The fellow will be required to attend a bi-weekly Post-doctoral Fellows Core Seminar and the weekly Post-doctoral Substance Abuse Seminar. The Trauma fellow will also attend the weekly PTSD Seminar (see Appendix B for complete seminar descriptions). The seminars are geared at an advanced level, with emphasis on case examples of complicated patients and increase in complexity and sophistication over time. The fellows make a formal presentation in seminars during the training year. See Appendix C for recent Sample Seminar Curricula.

There will be three to six hours weekly of supplemental structured learning activities. Such experiences include case conferences, in-services, seminars and formal scholastic presentations. Advanced readings from the evolving body of scientific knowledge will be assigned (see Appendices B & C)

Professionals from other disciplines provide adjunct supervision/consultation within their area of expertise.

Written evaluations are designed to provide explicit feedback on strengths and deficiencies and suggest corrective actions.

Faculty

(N.B. Biographic summaries of all faculty are included in Appendix A)

Administrative Faculty

Russell Lemle, Ph.D. Director of Post-doctoral Psychology Training and
. Chief Psychologist, Mental Health Service

Clinical faculty

Patrick Reilly, Ph.D., Chief, Substance Abuse Outpatient Programs
Victoria Tichenor, Ph.D., PCT Director of Training
Johannes Rothlind, Ph.D., Director, Psychological and Neuropsychological Assessment Program
Stephen Pennington, Ph.D. , Staff Psychologist
Paula Domenici, Ph.D., Staff Psychologist, PCT
Yong Song, Ph.D., Staff Psychologist, Opioid Replacement Team

Teaching Faculty

Joan Zweben, Ph.D. Senior Psychologist, Substance Abuse Programs
Peter Banys, M.D. Chief, Substance Abuse Programs
Victoria Tichenor, Ph.D. PCT Director of Training
Frank Schoenfeld, M.D. Chief, PCT
Mardi Horowitz, M.D. Director of the Center on Stress and Personality, UCSF

Research Mentors

Patrick Reilly, Ph.D., Chief of Substance Abuse Outpatient Clinic
Suzanne Best, Ph.D. PTSD Senior Research Psychologist
Charles Marmar, M.D. Chief, Mental Health Service
Tom Neylan, M.D. PCT Medical Director
Timothy Carmody, Ph.D. Director, Health Psychology Program
James Sorensen, Ph.D. UCSF Adjunct Professor of Psychiatry

Overall Structure of Fellowship

The fellowship begins on September 1, 2005. At the beginning of the training year, the fellow will develop individualized training plans across the seven competencies for each rotation (see Appendix E, Sample Psychology Training Plan), including matching to a research mentor, if desired. This plan will take into account the fellow's baseline strengths, deficiencies and training goals. The Steering Committee will review and modify as warranted.

At the end of the year, final systematic written evaluations of the fellow will be completed. A Psychology Trainee Evaluation form is appended (see Appendix D, Psychology Trainee Evaluation Form). Applicable due process policies and procedures for fellows are appended (see Appendix F, Due Process Policies and Procedures). Post-doctoral fellows will have approximately 45 hours per week assigned. Weekly supervision will occur with psychologist supervisors on each rotation. Clinical assignments on the PCT, SRCBOC, DAT, ORT, SUPT and PNAP are outlined below. Both fellows will receive didactic and clinical experience with PTSD and addicted populations. Both will attend a weekly PTSD seminar, a weekly Substance Abuse fellows seminar, and a biweekly SUPT Clinical Conference. One fellow will function as part of the PCT Team for the entire year, for approximately 18 hours per week (Trauma Emphasis). The other fellow will function as part of the Substance Abuse Teams for 18 hours for the entire year (Addiction Emphasis). Both fellows will function on the SUPT team for 10 hours per week for the year and both will perform evaluations and supervision in the PNAP program for 4 hours per week for the entire year. For those fellows on the PCT Team, their work on the SUPT Team will tend to emphasize addiction issues, while for those fellows on the Substance Abuse Teams, their SUPT work will tend to emphasize assessment, treatment and management of trauma issues.

1. *SUPT Team.* The fellow's experiences on this rotation include a process focused group that explores the interpersonal consequences of PTSD and SA, phase oriented groups calibrated for the level of substance abuse recovery and affect tolerance, and didactic groups (anger management, relapse prevention). Individual therapy will include cognitive, psychodynamic and information processing therapies. The fellow will attend the weekly interdisciplinary team meeting at which treatment plans are updated and discussed, new intakes are presented and periodic didactic presentations are made. Time assigned is approximately 10 hours weekly for 12 months. Both fellows.

2. *PCT.* On this rotation, the fellow's experiences will include a trauma focused group, individual psychotherapy utilizing manualized CBT techniques such as information processing therapy, psychoeducation (covering PTSD symptom management, psychophysiology of PTSD, sleep disorders, history of the Vietnam War), family therapy with a systems oriented approach, PTSD consultation to the medical center and interprofessional team meetings. Time assigned is approximately 25 hours/wk. Trauma Fellow.

3. *Santa Rosa CBOC* Santa Rosa Community Based Outpatient Clinic, Mental Health Service (SR MHC). (Robert Nadol, M.D. Chief; Patrick Reilly, Ph.D., Associate Chief). The SR MHC is located 55 miles north of San Francisco and is a satellite clinic of the San Francisco VA. The SR MHC serves veteran patients predominately from Sonoma, Marin, Napa, Lake, and Mendocino Counties. The clinic provides high quality care for veterans with mental health problems, emphasizing chronic severe mental illness, combat- and sexual-assault related posttraumatic stress disorder, substance abuse, late life depression and dementia, mental health problems of homeless veterans, and psychiatric illness co-occurring with medical illnesses. The SR MHC consists of a multidisciplinary treatment team including four psychiatrists, two psychologists, two registered nurses, a social worker, a readjustment counselor, a postdoctoral psychology fellow, and two predoctoral psychology practicum students. Drs. Patrick Reilly and Stephen Pennington provide clinical supervision in the clinic. Time assigned 16 hours/week for the Addictions Fellow.

4. *DAT Team.* On this rotation, fellows will lead the weekly team meetings and review initial and updated treatment plans. They will conduct phase-oriented groups calibrated for the level of substance abuse recovery, lead a process focused group that explores the interpersonal consequences of substance abuse, facilitate (or co-facilitate) an anger management group, a dual diagnosis group, and lecture in a patient education. They may conduct substance abuse consultations to the medical center. They will visit community substance abuse clinics. Time assigned is approximately 18 hours weekly for the DAT and ORT together. There will also be off-station rotations available for this fellow, including rotations at a residential substance abuse facility in Oakland for female addicts who have extensive trauma histories. Addiction Fellow 3 hours/week.

5. *ORT Team.* The fellow's experience on this rotation will be similar to that of the DAT Team, except the focus will be on the treatment of heroin addicts who take opioid replacement medications such as methadone or LAAM. Fellows will lead the weekly team meetings and review initial and updated treatment plans. They will conduct phase-oriented groups organized around levels of privilege and frequency of take-out doses, facilitate (or co-facilitate) an anger management group, a dual diagnosis group, and lecture in a patient education class on relapse prevention principles, the drug use cycle, and health promotion. Addiction Fellow 5 hours/week.

6. *Psychological and Neuropsychological Assessment Program.* The fellow will be assigned assessments that involve particularly complex questions about cognitive status, neuropsychological issues or complicated issues in personality and psychopathology of addicted or traumatized patients. Fellows will have the opportunity to supervise psychology interns in their assessment efforts with addicted and/or traumatized patients. Time allocated is approximately 4 hours weekly for 12 months. Both Fellows.

The two fellows will meet bi-weekly with the Director of Training in a Post-doctoral Fellows Core Seminar. This seminar covers the range of generalist skills pertaining to being an advanced professional psychologist, in addition to readings deemed important in the developing areas of addiction and trauma. There are a number of additional seminars and educational opportunities in which the fellow will be encouraged to attend, given his/her particular interest and training goals (see Appendix B for complete seminar descriptions).

Approximately six hours weekly may be devoted to research activities or a scholarly project. If desired, the fellow will select a research mentor and meet weekly to discuss planned or ongoing research or a scholarly project. S/he will have the opportunity to join one of the existing PTSD or SA projects and pick a topic of research interest. S/he will have the opportunity to collaborate in the development of grants for new research projects. S/he will also attend regularly scheduled research laboratory meetings.

Fellows will attend the 45 minute weekly meeting of all Psychology faculty. They are invited to contribute as colleagues to discussions regarding training and professional development.

For one hour weekly, the fellow will supervise pre-doctoral trainees, including psychology interns and psychology externs.

Facilities/Resources

The fellow will have an assigned office. Clinical space will be provided on assigned rotations. The fellow will have a computer in his/her office which has access to the Internet and on-line lit search resources as well as word processing and medical record keeping. There is a broad range of psychological and neuropsychological tests available. Clerical support is available through each treatment unit as well as through Psychological Services. The SFVAMC Medical Library has over 350 current journal subscriptions, 43 of which are mental health related. Medline and Psych Info searches are provided through the library, as are numerous other resources. Fellows also have access to the medical library of UCSF, with its 2,600 current journals and Center for Knowledge Management services. Salary is $40,000 yearly. (The fellow may apply for up to $5000 in TRC Pilot Study non-salary money for new substance abuse research.) Federal employee health insurance is available to fellows.

For the last two years, up to $900/year has been available to attend professional conferences. We expect these funds to continue.

APA Accreditation

Our fellowship (Postdoctoral Fellowship in Clinical Psychology with Emphasis in PTSD and Substance Abuse) is accredited by the American Psychological Association Committee on Accreditation.

APPIC Membership

Our fellowship has been granted membership in the Association of Psychology Postdoctoral and Internship Centers (APPIC). Our fellowship is thus listed in both the printed and on-line APPIC member directories. The web address for APPIC to access the on-line directory is: www.appic.org.

California Licensure

The Fellowship will provide and satisfy the California Board of Psychology's requirement for 1500 hours of supervised post-doctoral experience.

Application Information

Eligibility: Candidates must be graduates of APA-accredited doctoral programs in clinical or counseling psychology and must have completed an APA-accredited internship. All requirements for the doctoral degree must be completed prior to the start of the fellowship year. Persons with a Ph.D. in another area of psychology who meet the APA criteria for respecialization training in Clinical or Counseling Psychology are also eligible.

Application: All application materials must be post-marked by January 28, 2005. The fellowship begins on September 1, 2005. For a copy of the application, contact Russell Lemle, Ph.D., Director of Psychology Training, Mental Health Service (116B), San Francisco DVAMC, 4150 Clement Street, San Francisco, CA 94121. His telephone is (415) 221-4810 ext. 2348; his e-mail is russell.lemle@med.va.gov.

Selection: Selection will involve review of written application materials, three letters of reference, and in-person or telephone interviews with each member of the Post-doctoral Steering Committee. Selection criteria will include "goodness of fit" in terms of complementary interests, attitudes and experience in the areas of PTSD and SA, as well as the quality of the applicant's educational, scholarly and clinical skills. Notification of acceptance will occur on March 16, 2005.

Appendix A

FACULTY BIOGRAPHIES

Peter Banys, M.D.

Dr. Banys has directed the Substance Abuse Programs and the Substance Abuse Physician Fellowship at the SF-VAMC for the past 20 years. He is Associate Clinical Professor of Psychiatry at UCSF. Dr. Banys has developed a phase model of recovery that guides treatment in these programs. Twenty-five fellows have completed the fellowship and have obtained junior faculty appointments at UCSF, Stanford, University of Pennsylvania, Yale and elsewhere Others have gone to work for Kaiser Permanente, City and County of San Francisco, and other community agencies such as the Haight Ashbury Free Clinics. He is active in clinical research and is currently engaged in a long-term trial of naltrexone for alcohol relapse prevention. Dr. Banys was educated at Harvard University (as a National Merit Scholar), and obtained his MD from Case Western Reserve School of Medicine in 1973. He is a longtime Chair of the Education Committee of the California Society of Addiction Medicine (CSAM) and a member of national Conference Planning Committees of ASAM and CSAM. Dr. Banys is the recipient of the Federal Employee of the Year Award from the VA, and the Vernelle Fox Award from CSAM for Excellence in Physician Teaching. He is president-elect of CSAM.

Suzanne Best, Ph.D.

Suzanne Best is the Senior Research Psychologist in the PTSD Research Program at the SF-VAMC. She is currently Project Director of a multi-site NIMH funded study of posttraumatic stress in police officers and is Acting Project Coordinator of the PTSD core of a Mental Illness Research, Education, and Clinical Center grant (MIRECC), a VA funded multi-site program that includes six PTSD research protocols. Dr. Best received her doctorate in Clinical Psychology in 1996 from the California School of Professional Psychology, Alameda. Her primary research interest is in the study of couples and families where one of the members is diagnosed with PTSD. Her current activities in this area include a supplemental study of spouses and partners of police officers and a pilot study of psychophysiological and emotional responses in couples with PTSD.

Timothy P. Carmody, Ph.D.

Dr. Carmody is Director of the Health Psychology and Psychology PRIME Programs and Clinical Professor in the Department of Psychiatry at the UCSF. He has been a member of the Psychological Services staff since 1985. Dr. Carmody received his doctorate in clinical psychology from the University of Montana in 1977. For eight years, he was a faculty member in the Department of Medical Psychology at the Oregon Health Sciences University. His professional interests include chronic pain, nicotine dependence, psychological factors in the prevention and treatment of coronary heart disease, stress/anxiety management, biofeedback, and obesity/weight control. He has conducted research and published in a variety of areas in behavioral medicine including smoking cessation, coronary risk factors, pain management, dietary management of hyperlipidemia, coronary-prone behavior, and medical adherence. Dr. Carmody has been the recipient of a Research Career Development Award from the National Heart, Lung, and Blood Institute (NHLBI) and has served on several ad hoc grant review committees for NHLBI. His research has been funded through the VA HSR&D Program and the University of California Tobacco-Related Diseases Research Program. He is currently the principal investigator or co-investigator on two funded research studies on smoking cessation. He serves as an editorial consultant to several professional journals.

Paula L. Domenici, Ph.D.

Paula L. Domenici, Ph.D., is a staff psychologist on the Posttraumatic Stress Disorder Clinical Team (PCT). Dr. Domenici received her doctorate in Counseling Psychology from the University of Maryland in 2002; completed her internship at the Baltimore VAMC and postdoctoral fellowship at the San Francisco VAMC. Dr Domenici has been a member of the PCT staff since 2004. Dr. Domenici coordinates intake screenings and group therapies for the PCT. She has developed and leads the partners support feature of the PCT. She also conducts evaluations, leads therapy groups, and performs individual therapy. Dr. Domenici provides supervision to psychology interns, externs and fellows and teaches psychiatry residents in training with the PCT and participates in the PCT educational seminar. She is helping to spearhead services to returning soldiers from Iraq with PTSD. She currently is participating as a clinician on a CBT study that incorporates skills training and exposure therapy for Vietnam War veterans.

Mardi J. Horowitz, M.D.
Dr. Horowitz is the Director of the Center on Stress and Personality at UCSF, and has been a pioneer in the understanding and treatment of trauma-related problems. His accomplishments and awards (including the John D. and Catherine T. MacArthur "genius" award from 1984-1994) are literally too numerous to list in their entirety here. His book on Stress Response Syndromes has become a classic and his research and thinking about reactions to stressful life events culminated in the official codification of PTSD in the diagnostic nomenclature. His recent books (Formulation as a basis for Planning Psychotherapy Treatment; and Cognitive Psychodynamics) form the basis of his Advanced Psychotherapy Seminar, in which trainees from several of the mental health disciplines come together to learn an approach to psychotherapy that integrates key concepts from cognitive science and psychodynamic theory.

Russell Lemle, Ph.D. is Chief Psychologist and Psychology Training Director, Mental Health Service and Associate Clinical Professor, UCSF Medical School, Department of Psychiatry. He obtained his doctorate from SUNY at Buffalo in 1979. He completed his predoctoral internship at UCLA Neuropsychiatric Institute in 1978 and his postdoctoral fellowship in Family Therapy at Langley Porter Psychiatric Institute. Between 1984 and 1993, he was Chief of the SFVAMC Outpatient Alcohol Clinic, during which period he authored clinical articles on alcohol treatment and etiology. Since 1992, he has been the Chief Psychologist. Other areas of professional interest and teaching include counter-transference, couples and group therapy. Dr. Lemle is on the Planning Committee of the yearly national VA Psychology Leadership Conference and postdoctoral fellows are encouraged to attend the conference. In 2003, he received the Association of VA Psychology Leaders Leadership Award for his significant contributions to national VA Psychology issues. Dr. Lemle is a Fellow in the APA Division 18 (2004).

Charles Marmar, M.D.
Dr. Marmar is a Professor of Psychiatry in the Department of Psychiatry at the University of California. Dr. Marmar is currently Associate Chief of Staff, Mental Health Service at the SF-VAMC, and the Vice Chair of the Department of Psychiatry, UCSF. Dr. Marmar is internationally recognized as one of the outstanding figures in the field of Posttraumatic Stress Disorder. His publications are prolific and varied.

Dr. Marmar earned his MD from the University of Manitoba, Canada in 1970. He subsequently completed a residency in psychiatry at the University of Toronto, and was the R. Samuel McLaughlin Research Fellow in Stress and Anxiety, in the Psychiatry Department at the UCSF, from 1977-78. Dr. Marmar is engaged in a broad range of research areas in PTSD. He is examining the nature of acute stress response and risk factors for acquiring PTSD and resiliency in preventing it. Closely linked to this effort is Dr. Marmar's inquiry into neurobiologic mechanisms of PTSD, including: studies of sleep, neuroendocrine changes, sensory gating, event-related potential and neuroanatomic changes. He has been an important contributor to the development of a manualized form of trauma-focused group therapy, which is being tested in the national multi-site VA Cooperative Study 420, the largest study of its kind, for PTSD ever undertaken. Dr. Marmar is one of the world's experts on the question of dissociation and PTSD. Dr. Marmar is the Associate Director of the Mental Illness Research, Education and Clinical Center (MIRECC) recently awarded to Sierra Pacific VISN 21. He is the director of the PTSD core of the MIRECC.

Dr. Marmar has served as president of two major research societies, The Society for Psychotherapy Research and the International Society for Traumatic Stress Studies. He has served as the Chairman of the Violence and Traumatic Stress Initial Review Group at NIMH, the Scientific Advisory Board to the National Vietnam Veterans Readjustment Study and the Department of Veterans Affairs Deputy Assistant Secretary's Resource Committee for PTSD. Dr. Marmar has served as an editorial board member and reviewer for numerous scientific journals. He is the founder and was the Director of the Posttraumatic Stress Disorder Program at the San Francisco VA Medical Center until 1996.

Dr. Marmar has received a number of honors for his scientific contributions and community service including the Robert Laufer Memorial Award for Outstanding Scientific Achievement from the International Society for Traumatic Stress Studies and the Department of Veterans Affairs Chief Medical Director's Honor Award for public service after the Loma Prieta earthquake.

David Mohr, Ph.D.
David C. Mohr, Ph.D. is Assistant Clinical Professor in the Departments of Psychiatry and Neurology at the University of California, San Francisco and a research psychologist at the San Francisco VA. He received his Ph.D. from the University of Arizona in 1991. Dr. Mohr maintains an active research program that focuses on the evaluation of psychosocial intervention in medical populations and mind-body relationships. These research programs have been

funded by the National Institute of Mental Health, the National Multiple Sclerosis Society, as well as several private foundations and corporations. He has recently completed several studies that include 1) a comparative outcome study of three forms of treatment for depression in multiple sclerosis (MS), 2) investigation of the effects of depression and treatment for depression on MS-related autoimmune activity, 3) examination of the relationship between stress and the development of new brain lesions in MS, and 4) the development of a treatment model to train injection phobic patients to self-inject medications, and 5) the development of a model of delivering treatment for depression over the telephone for mobility impaired patients. Currently he has studies evaluating the effects of telephone psychotherapy on depression, disability, handicap, and MS disease activity. He is also developing a brief intervention for couples in which one partner is expected to die of cancer within 1 year. The goals of this intervention are to improve quality of life and end of life care, and to reduce the risk of complications in bereavement in the surviving partner. Dr. Mohr is also involved in the development of treatment guidelines for multiple sclerosis as a member of the Multiple Sclerosis Council. As member of the APA Committee on Professional Practice and Standards, he is also assisting in the development of criteria to be used in the creation and evaluation of guidelines for psychology practice. Dr. Mohr is associate editor of *Journal of Clinical Psychology*.

Thomas Neylan, M.D.

Dr. Neylan received his medical school education from Rush Medical College, graduating in 1984, and completed his psychiatry residency at the University of Pittsburgh. He began his research training at the University of Pittsburgh in a NIMH funded clinical research fellowship. He is currently the Medical Director of the PCT. Dr. Neylan is an Assistant Professor of Psychiatry in Residence at the University of California School of Medicine, San Francisco. In 1994, he joined the PTSD program in the Psychiatry Service of the SF-VAMC and directed the Evaluation and Brief Treatment of PTSD Unit (EBTPU). While serving in this position, Dr. Neylan developed several projects examining the biology of sleep and arousal disturbances in subjects with PTSD. He is the Principal Investigator on VA Merit Review grant studying brain event-related potentials in PTSD, a NIH First Award studying the role of the HPA axis in regulating sleep disturbances in PTSD, a study funded by the VISN 21 MIRECC to compare fluvoxamine, guanfacine, and placebo in the treatment of PTSD, and a study funded by Bristol-Myers Squibb studying the effect of nefazodone on the treatment of PTSD. He has numerous publications in psychiatric journals. Dr. Neylan has lectured extensively on PTSD to the medical students and psychiatry residents at the UCSF and to psychiatrists at national meetings such as the American Psychiatric Association, the American Sleep Disorders Association, and the International Society for Traumatic Stress Studies. Dr. Neylan has received several awards for his teaching.

Stephen Pennington, Ph.D.

Dr. Pennington has been a Staff Psychologist since 1971. He began his clinical study of PTSD and men's issues in 1973, and in 1980 developed a special interest in integrative approaches to psychotherapy. In 1990 he joined the PCT to help establish the PTSD Inpatient Program. In 1996 he went to the VA Community-Based Outpatient Clinic in Santa Rosa to set up the PTSD treatment program. He received his Ph.D. in Clinical Psychology at the University of Pittsburgh, and came to UC San Francisco for a Fellowship in Medical Psychology, where he is an Assistant Clinical Professor. He has given many workshops on the treatment of PTSD, delivered a paper on the integrative approach to PTSD at the Society for the Exploration of Psychotherapy Integration, and has written educational materials for patients about PTSD, Anger Control, and meditative approaches to Stress Reduction.

Patrick M. Reilly, Ph.D.

Patrick M. Reilly, Ph.D. is Chief of the Substance Abuse Outpatient Clinic at the SF-VAMC and an Associate Clinical Professor in the Department of Psychiatry at the University of California, San Francisco. He received his doctorate in counseling and health psychology from Stanford University in 1989, where he was an American Psychological Association Minority Fellow. His professional interests include substance abuse treatment, anger management, and the treatment of violent behavior. He has been an Investigator on several federally funded research studies on anger management and cocaine dependence. He is also an investigator on several research studies focusing on the treatment of drug dependence, including grants awarded by the National Institute on Drug Abuse (NIDA) and the Veteran's Administration. He was awarded the 1999 Interdisciplinary Achievement Award by the Langley Porter Psychiatric Institute Alumni-Faculty Association at UCSF. His recent publications include "Anger Management for Substance Abuse and Mental Health Patients: A Cognitive-Behavioral Therapy Manual" through the Center for Substance Abuse Treatment, in Washington, D.C., "Anger Management Group Treatment for Cocaine Dependence: Preliminary Outcomes" in the American Journal of Drug and Alcohol Abuse, "Self-Efficacy and Illicit Opioid Use in a 180-Day Methadone Detoxification Treatment" in the Journal of Consulting and Clinical Psychology, and "Anger Management

and Temper Control: Critical Components of Posttraumatic Stress Disorder and Substance Abuse Treatment" in the Journal of Psychoactive Drugs.

Johannes C. Rothlind, Ph.D.
Dr. Rothlind is Director of the Neuropsychology Clinic at the SF-VAMC. He is an Adjunct Assistant Professor of Psychiatry at UCSF. Dr. Rothlind obtained his doctorate in Clinical Psychology from the University of Oregon in 1990, and completed post-doctoral fellowship in clinical neuropsychology research at the Johns Hopkins University School of Medicine from 1990-1992. His current responsibilities included carrying out clinical consultations in the Neuropsychology Clinic and in the Neurology Memory Disorders Clinic at the VA. He supervises clinical psychology interns and fellows in assessment and clinical consultation activities. Together with interns and fellows, he provides consultations to the PTSD and Substance Abuse programs, assisting in the evaluation of mood and emotional functioning, personality, intellectual and memory functioning, Amnestic syndromes, Dementia, Learning Disabilities and Attention Deficit Hyperactivity Disorder. He conducts weekly training seminars and case-conferences for trainees, reviewing basic topics in assessment and empirical foundations of clinical neuropsychological assessment and consultation. He is currently involved as a co-investigator or consultant on several funded research projects examining neuropsychological functioning in PTSD, Parkinson's disease, and in HIV+ individuals who are heavy drinkers.

Frank Schoenfeld, M.D. Dr. Frank Schoenfeld has devoted his 34-year career, as a psychiatrist in government service, to the treatment of combat-related stress disorders. Dr. Schoenfeld is the Director of the Posttraumatic Stress Disorder Program at the San Francisco Department of Veterans Affairs (DVA) Medical Center. He is a member of the Department of Veterans Affairs Undersecretary for Health's Special Committee on PTSD, tasked with charting the future direction of services for the nation's veterans with PTSD. Dr. Schoenfeld is also Clinical Professor of Psychiatry at the University of California School of Medicine, San Francisco, where he excels as a teacher of advanced principals of pharmacology for chronic mental disorders. Dr. Schoenfeld was instrumental in designing a four-stage treatment model for chronic complex PTSD that has influenced ambulatory care of veterans nationwide. Under his clinical leadership the San Francisco PTSD Program has grown to become one of the nation's largest outpatient programs for veterans with PTSD and is one of two programs recognized by the DVA as a Clinical Program of Excellence. Dr. Schoenfeld was honored by the San Francisco Bay Area Federal Executive Board as the Federal Employee of the Year in the professional category in 2000.

Yong S. Song, Ph.D. Dr. Song is a staff psychologist in the Opioid Replacement Team (ORT) of the Substance Abuse Outpatient Clinic (SAOPC) and Assistant Clinical Professor in the Department of Psychiatry at UCSF School of Medicine. In the ORT clinic, Dr. Song supervises the delivery of psychosocial care and provides direct clinical services to patients with primary opioid dependence. Dr. Song is a graduate of the predoctoral internship program at the San Francisco VA Medical Center (1997-1998). Dr. Song subsequently received his PhD in Clinical Psychology from Virginia Commonwealth University, and completed a NIDA-funded NRSA postdoctoral fellowship in Drug Abuse Treatment Research at UCSF. Prior to joining the faculty at the San Francisco VA Medical Center in 2004, Dr. Song served on the faculty of the UCSF-Langley Porter Psychiatric Institute's Clinical Psychology Training Program (CPTP) while he served as the Program Director for the Opiate Treatment Outpatient Program at San Francisco General Hospital. Dr. Song's current research interests include improving health promotion behaviors among substance users in treatment, particularly patients with infectious diseases (e.g., HIV, HCV). Currently, he is participating as the site PI for a NIDA/CTN-funded multi-site randomized trial testing a behavioral intervention to reduce HIV-risk behaviors among men in drug treatment.

James Sorensen, Ph.D.
Dr. Sorensen is an Adjunct Professor of Psychiatry at UCSF. His research in drug abuse began 20 years ago, directing a NIDA-funded double-blind study of detoxification from heroin. An experienced investigator, he has published over 150 articles, chapters, and books, the most recent about preventing AIDS in drug abusers. An experienced leader, Dr. Sorensen was the Chief of Service for Substance Abuse Services at San Francisco General Hospital from 1982 through 1995 and has led seven NIH R01 research grants. He was the Director of the San Francisco Treatment Research Unit from 1990 through 1995, and leads or participates in numerous other NIH and non-governmental supported research and training programs.

Victoria Tichenor, Ph.D.
Dr. Tichenor is the Director of Training and the coordinator for individual therapies in the PCT and is one of the founders of the Family Therapy and women's clinical services components of the PTSD Program. She received her

Ph.D. in Counseling Psychology at the University of Maryland (1989), and is currently is an Assistant Clinical Professor of Psychiatry at the UCSF. She has been a member of the PCT staff since 1989. She has published PTSD in the family therapeutic alliance articles on the relationship of peritraumatic dissociation and PTSD in female Vietnam Theater veterans. Dr. Tichenor has engaged in group therapy research, using a psychodynamic model to treat women with PTSD. She has also been a member of a research team using a behavioral approach in trauma-focused group.

Joan Zweben, Ph.D.

Dr. Zweben is a nationally known dinical psychologist with over thirty years' experience in treating addiction and training treatment practitioners. The practitioners include peer counselors, social workers, marriage and family counselors, psychologists, probation officers, nurses and physician. She has a broad-based background in both alcoholism and drug dependence, and has experience with both residential and outpatient modalities.

Dr. Zweben received her doctorate in Clinical Psychology from the University of Michigan at Ann Arbor in 1971. She is currently Clinical Professor of Psychiatry, UCSF. She has been awarded the Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders from the American Psychological Association (1996), and is also a Fellow of Division 50 of the APA (1998).

Dr. Zweben is the founder and Executive Director of the East Bay Community Recovery Project and The 14th Street Clinic & Medical Group and has steadily developed the medical and psychological services of these affiliated organizations. She is the author of two books, numerous articles and book chapters, and is the editor of 12 monographs on treating addiction.

Appendix B

Post-doctoral Fellowship Seminars and Educational Offerings

Post-doctoral Fellows Core Seminar
The Director of Psychology Training meets biweekly with both fellows in a 45 minute post-doctoral core seminar. It focuses on development of broad diagnostic and treatment skills pertaining to being an advanced professional psychologist. It teaches supervision, consultation and leadership abilities. Ethical, legal, DSMIV, cultural diversity and career direction issues are discussed. The fellows' work is reviewed. Readings are assigned.

Post-doctoral Substance Abuse Seminar
The Substance Abuse Seminar is a weekly collegial one-hour forum required for post-doctoral fellows. It is directed by Peter Banys, M.D. and Joan Zweben, Ph.D. Attendees include 3-4 physician fellows, 2 psychologist fellows, and four core faculty. The seminar serves a three-fold purpose. First, it provides a highly organized reading and discussion experience through the most significant areas of substance abuse methods. In this respect, a syllabus of readings is provided. Second, it provides an opportunity for fellows to present work-in-progress for scholarly articles, oral presentations, and research summaries. Finally, it serves as a forum for faculty to present and review grant submissions and nascent research ideas.

PTSD Seminar
The weekly one hour PTSD Seminar, will be run by the Trauma fellow during his/her PTSD semester, under the supervision and direction of Victoria Tichenor, Ph.D. It is attended by a multidisciplinary staff of psychologists, psychiatrists, nurses, a social worker, pre and post-doctoral psychology trainees, and psychiatry fellows and residents. At the beginning of the training year, meetings consist of didactic presentations covering epidemiology of PTSD, assessment, characteristics of our population, physiology of PTSD, psychopharmacology and modalities of treatment. Following this introductory phase, trainees present both assessments for disposition and cases for clinical discussion. Each fourth week, a didactic presentation is given, covering such topics as dissociation and sleep, as well as various interventions such as exposure, information processing and psychodynamic therapies. Clinical and physiological research investigators are invited to discuss their ongoing research in the seminar as well. In addition to presenting cases, the post-doctoral fellow would present a topic of interest during one of the later didactic sessions.

PTSD Research Meeting
This two-hour meeting is held every other week. Its primary focus is the development of new ideas and research protocols. In house studies are reviewed critically by peers, and guests are invited to present PTSD research. Recommended for the fellow who chooses a PTSD research topic.

SUPT Clinical Conference
This is a one-hour meeting held weekly among all the interprofessional staff and trainees of the SUPT program, including both post-doctoral psychology fellows. The conference alternates between case presentations (including psychodynamic formulations of patients with PTSD and Substance Abuse), and didactic presentations of material relevant to treatment of these populations. Both fellows have the opportunity to present at this conference.

PTSD Conferences
As a core site for the VISN 21 Mental Illness Research, Education and Clinical Center (MIRECC), the PTSD Program sponsors monthly VTEL grand rounds teleconferences, mini-residencies at the VA Palo Alto Healthcare System, and regular network meetings. Topics focus on cutting edge scientific findings and clinical applications regarding dementia in PTSD patients and advanced PTSD principles in sexual assault and combat.

Grand Rounds
At SFVAMC, Mental Health Service Grand Rounds are held monthly. At UCSF, the Department of Psychiatry sponsors grand rounds weekly. They are one hour forums where invited nationally recognized experts and university faculty present on cutting edge research and clinical innovation. Fellows are invited to present their research or a complex treatment case at the SFVAMC Grand Rounds.

Advanced Psychotherapy Seminar with Mardi Horowitz

A weekly Advanced Psychotherapy Seminar is taught by Mardi Horowitz, M.D. who is the Director of the Center on Stress and Personality at UCSF. Dr. Horowitz has been a pioneer in the understanding and treatment of trauma-related problems. UCSF and SFVAMC psychiatrists, psychologists, social workers, psychology interns, psychiatry residents, psychology fellows, and social work interns attend this seminar. It focuses on planning, formulating and conducting psychotherapy from Dr. Horowitz' blend of psychodynamic, interpersonal, cognitive-behavioral and family system approaches as outlined in his 1997 book titled: Formulation as a Basis for Planning Psychotherapy Treatment. Videotaped session review, consultation of case material, discussions of selected readings, and lectures form the basis of the seminar. Topics involving trauma and trauma-related problems such as PTSD or bereavement are often discussed, particularly as they manifest in relation to varying personality styles or structures. Recommended for the fellow.

Neuropsychological and Psychological Assessment Seminar

A weekly Neuropsychology and Psychological Assessment Seminar is taught by Johannes Rothlind, Ph.D., the director of the Neuropsychological and Psychological Assessment Program at the SF-VAMC. The seminar provides a review of important foundations for clinical neuropsychological assessment. It includes a review of functional neuroanatomy, and advanced training in psychological and neuropsychological assessment and methods of psychological and neuropsychological consultation. In the seminar, trainees review clinical neuroscience literature pertaining to a variety of neuropsychiatric syndromes, including developmental disorders, ADHD, head trauma, PTSD, substance-abuse related dementia, normal cognitive aging, other dementing illnesses and Axis I and II disorders. Participants in the seminar examine clinical cases and develop advanced proficiency in integrating psychometric findings, history, and mental status examination in case-formulation, diagnosis, and treatment planning. Fellows are encouraged to attend and will present and preside over selected case conference meetings where topics of relevance to PTSD or Substance Abuse are discussed.

SFVAMC Family Therapy Seminar.

The family therapy seminar is run through the PCT and meets for one and a half hours weekly. Trainees are typically from psychology or psychiatry. Initial meetings are didactic. Topics include the extensive intake process including the use of measures to assess substance abuse, domestic violence and relational conflict, determination of therapeutic focus with operationalized goals, modalities of family therapy and use of reflecting teams. Following the initial didactic sessions, trainees are required to present one case and to bring a case for a reflecting team during seminar. Trainees function as consultants on cases and serve on the reflecting teams of their colleagues. As the seminar progresses, special topics concerning such issues as domestic violence or termination are presented.

Writer's Task Force

The Writer's Task Force is a structured bi-weekly group that includes trainees and junior faculty. It is led by Dr. James Sorensen. Activities include review of manuscripts, presentations by journal editors on the review process and what constitutes an interesting and publishable manuscript, and presentations on scientific writing by professional editors. The Writer's Task Force had as its goal the publication of one manuscript per participant each year. More experienced participants use the Task Force as a means of insuring that a manuscript will be written, and are encouraged to attend to assist junior members. A total of 38 trainees, fellows, and junior faculty members have participated in the Task Force since its beginning. A total of 27 manuscripts from the Task Force have been published or accepted for publication: these include 17 articles in peer-reviewed journals; 8 published abstracts; and 2 book chapters.

Appendix C Sample Seminar Curricula

PTSD Seminar Schedule

Date	Lecture	Faculty/Staff
January 20	Current SFVAMC Research Protocols	T. Neylan.
January 22	WW II, Korea & Vietnam Wars	F. Schoenfeld, Byron Wittlin. & Keith Armstrong,
January 29	Modern Deployment Wars	Patrick McGregor
February 5	Biological Bases of PTSD	T. Neylan
February 12	Pharmacology I	F. Schoenfeld
February 19	Pharmacology	F. Schoenfeld
February 26	CBT As a Treatment Model	V. Tichenor
March 4	PTSD Research	T. Neylan.
March 11	Debriefing	P. Domenici
March 18	DBT	G. Basten
March 25	Group Treatment	P. Domenici
April 1	Talking About Trauma	V. Tichenor
April 8	Case Presentation	
April 15	Malingering, Extern Presentation	
April 22	Case Presentation	
April 29	Termination	G. Rhodes
May 6	Case Preentation	
May 13	Transpersonal Psychotherapy Group	F. Hiatt
May 20	Case Presentation	
May 27	EMDR	D. Domenici
June 3	Case Presentation	
June 17	Team Luncheon	
June 24	Feedback	

SUPT Clinical Conference

(tentative schedule)

Topic		Date
SUPT Phase Model Part I	Odell	8/2
SUPT Phase Model Part II	Odell	8/16
Case Presentation	Ceppi	8/30
Relapse Prevention	Odell	9/13
Pharmacotherapy for comorbid PTSD and Addiction	Glatt	9/27
Case Presentation	Glatt	10/11
Vietnam War History	Koller	10/25
Control Mastery Theory	Park	11/8
No Meeting		11/22
Clinical Update on Shame and Guilt	Zaslav	12/6
Police Study	Ballenger	12/20
Trauma Outcomes	Vernon	1/3
Case Presentation		1/17
Systems Centered Group Therapy	Karpenko, Straznickas	1/31
Clinical and Cultural Correlates of PTSD	Odell	2/14
Case Presentation		2/28

SUBSTANCE ABUSE SEMINAR

Wednesdays, 1:00 PM – 2:15 PM

DATE	TOPIC	DISCUSSANT
2003		
Sep 3	Highlights of history	Joan Zweben, Ph.D./David Wasserman, Ph.D.
Sep 10	History, con't	David Wasserman, Ph.D.
Sep 17	Assessment	Joan Zweben, Ph.D.
Sep 24	"Reefer Madness"	Joan Zweben, Ph.D./David Wasserman, Ph.D.
Oct 1	Treatment models: Abstinence & Harm Reduction	Joan Zweben, Ph.D./David Wasserman, Ph.D.
Oct 8	No Meeting	
Oct 15	Treatment modalities: overview	Joan Zweben, Ph.D./David Wasserman, Ph.D.
Oct 22	Marijuana	Joan Zweben, Ph.D./David Wasserman, Ph.D.
Oct 29	Co-occurring disorders: Assessment and treatment issues	Joan Zweben, Ph.D./David Wasserman, Ph.D.
Nov 5	Motivational enhancement strategies	Joan Zweben, Ph.D./David Wasserman, Ph.D.
Nov 12	Motivational enhancement strategies	Joan Zweben, Ph.D.
Nov 19	Co-Occurring Disorders	David Wasserman, Ph.D.
Nov 26	No meeting	
Dec 3	Facilitating use of the self-help system	David Wasserman, Ph.D.
Dec 10	Marijuana	Tim Cermak, MD
Dec 17	Self Medication	Anisha
2004		
Jan 7	Research on genetics	Peter Banys, MD
Jan 14	Alcohol	Peter Banys, MD

Jan 21	Phases of recovery: tasks and activities	Fawad Malik, MD
Jan 28	No Meeting	
Feb 4	Methamphetamine	Murtuza Ghadiali, MD
Feb 11	Methamphetamine	Murtuza Ghadiali, MD
Feb 18	Quantum Change	Garnette Cotton, Ph.D.
Feb 25	Pain	Karen Larsen, MD
Mar 3	Quantum Change	Garnette Cotton, MD
Mar 10	Drug Policy Issues	Peter Banys, MD
Mar 17	Drug Policy Issues	Peter Banys, MD
Mar 24	Benzodiazepines & Insomnia	Dennis Lin, MD
Mar 31	Cluster B Disorders	John Straznickas, MD
April 7	Pain	Karen Larsen, MD
April 14	Pain	Karen Larsen, MD
April 21	Therapeutic Communities	Joan Zweben, Ph.D.
April 28	Addiction Treatment in Germany	Monika Koch, MD
May 5		
May 12	Case Conference	
May 19	Therapeutic Communities	Brian Greenberg, Ph.D.
May 26	Therapeutic Communities	Joan Zweben, Ph.D.
June 2	Dialectical Behavior Therapy and Addiction	Garnette Cotton, Ph.D.
June 9	Dialectical Behavior Therapy and Addiction	Garnette Cotton, Ph.D.
June 16		
June 23	Neurobiology of Addiction	John Straznickas, MD

June 30	No meeting	
July 7	Contingency Management Approaches to Drug Treatment.	Yong Song, Ph.D.
July 14	No meeting	
July 21	No meeting	
July 28	No meeting	
Aug 4	No meeting	
Aug 11	Prop 36: Role of Criminal Justice System	Peter Banys, MD
Aug 18	Methadone Maintenance: Medical Aspects	Scott Smolar, MD
Aug 25	Methadone Maintenance: Psychosocial Tx	

Revised: August 16, 2004

Appendix D - Psychology Trainee Evaluation
San Francisco Department of Veterans Affairs Medical Center

Trainee Name_____

Intern/Fellow Supervisor_____

Rotation _____ Dates_____

Please **rate trainee** for each competency item, using as a comparison an average trainee at the same level functioning at a level consistent with his/her training and experience. Use definitions supplied for descriptors.

1 **Excellent** (generally has good of ideas of own; generally tracks needs of the case well; generally applies supervisory input effectively; applies scientist-practitioner model to all aspects of the work)
2 **Good** (often has good ideas of own; often tracks needs of the case well; often applies supervisory input effectively; often applies scientist-practitioner model to various aspects of the work)
3 **Adequate** (with direction and supervision, can: track needs of the case adequately; is able to apply supervisory input adequately; understands and applies scientist-practitioner model adequately)
4 **Poor** (requires extensive direction in order to perform minimally competent work, and in some areas demonstrates problems which may or may not meet criteria for impairment (see Due Process procedures)
NA **Does Not Apply**

<u>Competency Objective #1 – Role as a Professional Psychologist</u>

Interacts **respectfully** with other professionals, including supervisors

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an appropriate sensitivity to the influences of **individual and cultural differences** on patient care

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates good knowledge of **ethical principles** and consistently applies them appropriately, seeking consultation as needed

1	2	3	4	NA
excellent	good	adequate	poor	

Trainee takes on **responsibility** for key patient care tasks, autonomously ensuring that tasks are completed promptly

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to establish **rapport** with patients, reliably identifying challenging patients and spontaneously making adjustments

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to **use supervision** effectively, including an awareness and acknowledgement of potential problem areas, conflicts, skill deficits, countertransference reactions, etc

1	2	3	4	NA
excellent	good	adequate	poor	

Competency Objective #2 – Evaluation and Assessment

Demonstrates competence in **administering and interpreting** the various instruments on the rotation

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates understanding of **mental status and diagnostic components** of disorders relevant to rotation

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to elicit relevant **history**, including interview, medical record review, staff consultation and appropriate use of collateral information

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to incorporate an **empirical and theoretical knowledge base regarding disorders** encountered on rotation

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to **identify and characterize relevant neuropsychological conditions**, including dementias, memory syndromes, learning disorders, attention deficit disorders, and intellectual deficits

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to conduct a competent evaluation that will assist in **treatment planning**, including likely response to treatment and useful treatment strategies

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to **write a well-organized psychological evaluation**, answering referral questions clearly, providing specific recommendations for patient care

1	2	3	4	NA
excellent	good	adequate	poor	

Comments_____
_____
_____
_____
_____
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_____

Competency Objective #3 – Psychological Treatment

Demonstrates an awareness of **empirical and theoretical knowledge base regarding issues in the treatment** of patients on the rotation

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to generate a useful **case formulation**

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to formulate appropriate therapeutic **treatment goals** in collaboration with the patient

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to competently conduct **individual therapy,** including use of well-timed, effective and appropriate interventions

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates ability to competently conduct **group therapy,** including use of well-timed, effective and appropriate interventions

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates familiarity with current practices in the **psychopharmacology** of patients, including when to refer to prescribing physicians

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates knowledge about the concepts and skills to conduct **family therapy**

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to understand and use **countertransference** reactions productively in treatment

1	2	3	4	NA
excellent	good	adequate	poor	

Comments_____
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_____

Competency Objective #4 – Consultation

Demonstrates general familiarity with the **practices of physicians, psychiatrists, social workers, nurses, addiction therapists, other intake professionals and discharge planners** and a corresponding ability to frame the relevant psychological issues in ways that meet these needs

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an awareness of **when to consult** with other professionals in the treatment or management of a patient

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to **communicate effectively** with referral sources, including eliciting relevant information and explaining psychological issues

1	2	3	4	NA
excellent	good	adequate	poor	

Comments_____
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Competency Objective #5 – Interprofessional Treatment Planning and Case Management

Demonstrates an ability to **function as a psychologis**t with advanced training on interprofessional teams in order to plan treatment

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates a comprehension of the **unique and shared contributions of other professionals** in developing a treatment plan

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to be an effective **case manager** with patients on the rotation

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to perform **crisis intervention** with patients having a variety of psychosocial problems

1	2	3	4	NA
excellent	good	adequate	poor	

Comments_____
_____
_____
_____
_____

Competency Objective #6 – Research

Demonstrates an ability to understand ways that research and scholarly inquiry become a part of professional practice and **inform clinical functions**

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to **plan, implement and analyze research**

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to make **formal scholarly presentations** to groups of peers.

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates familiarity with the use of **outcome measures** to assess the efficacy of treatment

1	2	3	4	NA
excellent	good	adequate	poor	

Comments_____
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_____

Competency Objective #7 – Supervision and Leadership

Demonstrates the skills, knowledge and self-confidence necessary to **supervise psychology trainees** in their work with patients.

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to **manage an outpatient program** team

1	2	3	4	NA
excellent	good	adequate	poor	

Demonstrates an ability to supervise and direct **QI functions** on an interprofessional team

1	2	3	4	NA
excellent	good	adequate	poor	

Comments_____
_____
_____
_____
_____
_____
_____

SUMMARY

Trainee's main strengths_____

Areas to improve_____

Explicit recommendations for future training_____

Please use reverse side for additional comments.

_____ _____

Supervisor's Signature Date

_____ _____

Trainee's Signature Date

Appendix E – Sample Psychology Training Plan
San Francisco Department of Veterans Affairs Medical Center
SUPT Rotation

Trainee Name_____

Intern/Fellow Supervisor_____

Rotation _____ Dates_____

The Trainee on this rotation will obtain supervised experience and demonstrate competencies in the following checked skill areas by the end of this rotation. Outcome for these competencies will be defined as met if supervisor's end-of-rotation evaluation rating on relevant competency objectives is at the "adequate" level or better.

Competency Objective #1 – Role as a Professional Psychologist

___Demonstrates **respectful** interactions with other team members

___Demonstrates appropriate **sensitivity to the influences of individual and cultural differences** on patients with PTSD and SA

___Demonstrates **ethical conduct** on the rotation

___Acts **responsibly** in accomplishing patient care tasks

___Demonstrates an ability to establish **rapport** with patients

___Demonstrates effective **use of supervision**, including awareness and acknowledgement of potential problem areas, conflicts, skill deficits, countertransference reactions, etc

__Appropriately **documents supervision**

Competency Objective #2 – Evaluation and Assessment of PTSD and SA

Demonstrates competence in **administering and interpreting** the following instruments (check those that apply): ___Addiction Severity Index, ___War Stress Inventory, ___Impact of Events Scale-Revised, ___Clinician Administered PTSD Scale, ___Mississippi Scale for Combat-Related PTSD, ___MMPI-2, ___Peritraumatic Dissociative Experiences Questionnaire, ___CAGE Test, ___State-Trait Anger Expression Inventory

____Demonstrate understanding of **mental status and diagnostic components** of PTSD and SA

____Demonstrates an ability to incorporate an **empirical knowledge base** regarding assessment of PTSD and SA

____Demonstrates an ability to **identify and characterize treatment relevant to neuropsychological comorbidities** in PTSD and SA, including dementias, memory syndromes, learning disorders, attention deficit disorders, and intellectual deficits

___Demonstrates an ability to conduct an expert evaluation that will assist in **treatment planning**, including likely response to treatment and useful treatment strategies

___Demonstrates an ability to perform **"motivational interviews"** with addicted patients, including an assessment of the patient's stage of change readiness

___Demonstrates familiarity and comfort in employing and enforcing **urine surveillance** procedures to monitor substance usage

___Other relevant competencies (include separate page)

Competency Objective #3 – Psychological Treatment of PTSD and SA

___Demonstrates awareness of **empirical and theoretical knowledge base regarding issues in the treatment** of PTSD and SA, including strategies appropriate to the patient's personality structure, predominant mode of stress response and readiness to change addictive behavior

___Demonstrates an ability to conduct **group and individual therapy** using cognitive, behavioral and psychodynamic interventions to help patients work through and process trauma-related issues

___Demonstrates an ability to employ **trauma-focused techniques** including information processing, exposure and psychodynamic techniques

___Demonstrates knowledge of concepts and skills in conducting **relapse prevention** groups

___Demonstrates knowledge of concepts and skills regarding **PTSD symptom management**

___Demonstrates familiarity with the concepts and skills necessary to conduct **anger management** groups employing didactic and cognitive-behavioral interventions

___Demonstrates familiarity with Horowitz' concepts regarding **stress response syndromes** and the ability to apply them with patients with differing types or levels of personality organization

___Demonstrates familiarity with the concepts and skills necessary to treat patients with **comorbid PTSD and SA**, such the **co-complicating effects** of each disorder on the other and the ability to manage denial about substance abuse

___Demonstrates an understanding of **12-step techniques and concepts**, and ways to deal with patient resistance to these approaches

___Demonstrates familiarity with current practices in the **psychopharmacology** of PTSD and SA

___Demonstrates knowledge about the concepts and skills to conduct **family therapy with PTSD and SA** patients and their significant others or extended families

___Demonstrates familiarity with concepts regarding **opioid replacement** with methadone and LAAM

___Other relevant competencies (include separate page)

Competency Objective #4 – Consultation

___Demonstrates familiarity with the **practices of physicians, psychiatrists, social workers, nurses, addiction therapists other intake professionals and discharge planners** and a corresponding ability to frame the relevant psychological issues regarding PTSD and SA in ways that meet these needs

___Demonstrates an ability to **analyze and clarify for other professionals** ways in which trauma and addiction should be assessed and managed in treatment. Examples might include consultation to medical teams where surgeries or other medical procedures are conducted that re-vivify trauma in patients with PTSD, or ways that pain control with narcotics for chronic pain sufferers in substance abuse recovery can be managed to avoid relapse

___Demonstrates an ability to **consult regarding comorbid PTSD or SA** issues for patients encountered in a clinic focused primarily on the other disorder

___Demonstrates an ability to perform an informed **neuropsychological consultation** regarding SA and PTSD

___Demonstrates an ability to discern when a **medication consult** is needed

___Other relevant competencies (include separate page)

Competency Objective #5 – Interprofessional Treatment Planning and Case Management

___Demonstrates an ability to **function as a psychologis**t with advanced training on interprofessional PTSD and SA teams in order to plan treatment

___Demonstrates comprehension of the **unique and shared contributions of other professionals** in developing a treatment plan

___Demonstrates an ability to be an effective **case manager** with PTSD and SA patients in trauma-focused or addiction-related programs

___Demonstrates an ability to perform **crisis intervention** with PTSD and SA patients having a variety of psychosocial problems

___Other relevant competencies (include separate page)

Competency Objective #6 – Research

___ Demonstrates an ability to understand ways that research and scholarly inquiry become a part of professional practice and **inform clinical functions**

___ Demonstrates an ability to **plan, implement and analyze research** related to PTSD or SA

___ Demonstrates an ability to make **formal scholarly presentations** to groups of peers.

___ Demonstrates familiarity with the use of **outcome measures** to assess the efficacy of PTSD and SA treatment

___Other relevant competencies (include separate page)

Competency Objective #7 – Supervision and Leadership

___ Demonstrates the skills, knowledge and self-confidence necessary to **supervise psychology trainees** in their work with PTSD and SA patients.

___ Demonstrates an ability to **manage an outpatient program** team

___ Demonstrates an ability to supervise and direct **QI functions** on an interprofessional team

___ Other relevant competencies (include separate page)

Appendix F Due Process Policies/Procedures

POLICY AND PROCEDURES FOR IMPAIRED TRAINEE PERFORMANCE AND DUE PROCESS
San Francisco DVA Medical Center
Psychological Services/Mental Health Service

I. Introduction

It is the purpose of the Psychology Fellowship Program to foster and to support the growth and the development of fellows during the training. An attempt is made to create a learning context within which the fellow can feel safe enough to identify, to examine, and to improve upon all aspects of his or her professional functioning. Therefore, fellows are encouraged to ask for and supervisors are encouraged to give feedback on a continuous basis. When this process is working, evaluations should, and in fact do, produce no surprises since a fellow is aware of his/her progress on an ongoing basis.

It is a goal of the fellowship for supervisors to work with fellows to identify both strengths and problem areas or deficiencies as early in the year as possible so as to be able to develop a plan to remedy the problem(s) and build on the strengths.

II. Definitions of Impairment

For the purposes of this document "impairment" is defined broadly as an interference to professional functioning which is reflected in one or more of the following ways:

1. an inability and/or willingness to acquire and to integrate professional standards into one's repertoire of professional behavior;
2. an inability to acquire professional skills in order to reach an acceptable level of competency, and/or
3. an inability to control personal stress and/or excessive emotional reactions which interfere with professional functioning.

Evaluative criteria which link this definition of impairment to particular professional behaviors are incorporated in the specific evaluation forms for clinical work which are completed by supervisors formally at quarterly intervals. These criteria are kept in mind throughout the year and discussions regarding progress with respect to them as well as others are discussed by the staff in an ongoing manner.

While it is a professional judgement as to when a fellow's behavior becomes more serious (i.e., impaired) rather than just problematic, for the purposes of this document a "problem" refers to a fellow's behaviors, attitudes, or characteristics which, while of concern and which require remediation, are perceived to be not very unexpected or excessive for professional in training. Problems typically become identified as "impairments" when they include one or more of the following characteristics:

1. the fellow does not acknowledge, understand, or address the problem when it is identified;
2. the problem is not merely a reflection of a skill deficit which can be rectified by academic or didactic training;
3. the quality of services delivered by the fellow is sufficiently negatively affected;
4. a disproportionate amount of attention by training personnel is required, and/or
5. the fellow's behavior does not change as a function of feedback, remediation efforts, and/or time.

III. Policy

A. It is the policy that fellows may fail a specific rotation, and/or entire fellowship and/or they may be terminated from the program prior to completion. It is expected that this will be a highly unusual event. Failure and/or termination may occur for any of the following reasons but it is not limited to this list:

1. incompetence to perform typical psychological services in this setting and inability to attain competence during the course of fellowship;
2. violation of the ethical standards of psychologists;
3. failure to meet the minimum standards for either patient contact, didactic training, or testing competence;
4. behaviors which are judged as currently unsuitable and which hamper the fellow's professional performance;
5. violation of DVA Medical Center regulations.

B. It is also the policy that the fellow can invoke his/her right of appeal as specified the Procedures and Due Process section of this document.

IV. Procedures and Due Process

A. Determination of "Impaired" Status

Whenever a supervisor becomes aware of a fellow problem area or deficiency which seems not be resolvable by the usual supervisorial support and intervention, it should be called to the attention of the Director of Training. The Director of Training will gather information regarding this problem including, if appropriate, an initial discussion with the fellow. The Director of Training will then present the situation to a meeting of the Fellowship Committee except the Psychology Director. A determination will then be made by consensus whether or not to label the fellow "impaired," which implies the possibility of discontinuing the fellowship. This will be done after a thorough review of the fellow's work and performance, and one or more meetings with the fellow to hear his/her point of view. If such a determination is made, a further decision is made by majority vote of the Fellowship Committee to either (1) construct a remedial plan which, if not successfully completed, would be grounds for termination; or (2) initiate the termination procedure.

B. Remedial Action

A fellow who is determined to be "impaired" but potentially able to benefit from the remedial action will be asked to meet with the Training Committee to discuss the concern(s) and to determine the necessary steps to correct it. When a plan for correction has been determined, the fellow will receive written explanation of the concern and specifics of the corrective plan. This plan will also specify the time frame for the corrective action and the procedure for determining that the correction has been adequately achieved. If the correction has not been accomplished, either a revised remedial plan will be constructed, or the Fellowship Committee will proceed to terminate the fellow.

C. Procedure for Termination and Appeal

1. Due Process

The fellow will be provided an opportunity to present arguments against termination at a special meeting of the Fellowship Committee.

2. Appeal

Should the Training Committee recommend termination, the fellow may invoke his/her right of appeal to the Psychology Director. The Psychology Director may appoint one or more psychologists to assist him/her in responding to the appeal. These psychologist would not be on the Training Committee (nor would have supervised the fellow) and may include someone from another fellowship program. The training program shall abide by the decision of the appeal process.

_____
Russell Lemle, Ph.D.
Director of Psychology Training

Date:_____

RL:gp 8/2004

PSYCHOLOGY INTERNSHIP AND FELLOWSHIP POLICY AND PROCEDURES
San Francisco DVA Medical Center

Trainee Progress and Performance Evaluation

1. Purpose

To establish the policies and procedures for monitoring intern and fellow progress and evaluating performance within the traineeship program.

2. Policy

a) Progress and performance within the internship and fellowship program is monitored continuously using both informal and formal evaluation processes. Such evaluation serves to monitor progress in accomplishing training objectives, provides regular feedback about trainee performance, ensures timely identification of clinical weaknesses or deficiencies, and guides active remedial efforts.

b) Periodic formal feedback about intern performance is provided to the Training Director of the trainee's graduate program.

3. Responsibilities

a) The Director of Training is responsible to the Chief Psychologist for carrying out the provisions of this policy.

b) Supervisors are responsible for formally monitoring the trainee's progress in achieving the specific training objectives identified and providing timely feedback to trainees.

c) The Director of Training is responsible for assuring that periodic feedback is provided to interns' programs.

4. Procedures

a) Supervisors continuously monitor trainee progress in the context of clinical supervision and are responsible for providing feedback directly to trainees. In the case of serious performance concerns that may or may not arise to the level of "impairment" (see Policy and Procedures for the Impaired Trainee), supervisors must apprise the Director of Training. Trainee performance is regularly discussed at meetings of the Internship and Post-Doctoral Committees.

b) Fellows receive formal performance evaluations by each supervisor every four months. This written evaluation is a culmination of an active, ongoing dialogue between supervisor and trainee.

_____
Russell Lemle, Ph.D.
Director of Psychology Training

Date:_____ *RL:gp 8/2004*

Appendix G

PTSD Clinical Team Description

The Posttraumatic Stress Disorder Clinical Team (PCT) specializes in the outpatient treatment of veterans who have PTSD related to combat, combat support, combat training, or sexual abuse or harassment in the course of active duty military service. In FY 1998 the PCT provided 10,626 clinic visits to 1,841veterans. Our PCT is one of the largest is the nation with regard to clinical activity.

The PCT treats veterans from all eras. The percentage distribution according to era is as follows: Vietnam (79%), World War II (10%), Korea (4%) and Persian Gulf (7%). The age range for the majority of our patients is from 45 to 50 years. Approximately 20% of our patients are geriatric and over 96% are male. Disruption in relationships is an important factor in our patients. Thirty-seven per cent of our patients are divorced and another 21% have never married. Approximately 71% of our patients are unemployed. The racial/ethnic distribution is Caucasian (50%), African-American (11%), Hispanic (7%) and Other (32%). Co-morbid psychiatric conditions are an important factor in the veterans seen in the PCT. A history of substance abuse (47%) is common in the veterans referred to our program. There is co-morbidity for affective disorders (43%) and anxiety disorders (24%). Irritability and violent outbursts are a common complaint, with 15% reporting a history of violent behavior.

The PCT is dedicated to providing comprehensive outpatient treatment for veterans suffering from posttraumatic stress disorder. Although we are in a densely populated urban location, our area of outreach covers eight counties in Northern California and extends nearly to the Oregon border. Because the veterans we treat suffer primarily from chronic PTSD, we believe they will require sustained and prolonged treatment. The secondary psychosocial effects of PTSD often pose as much a therapeutic challenge as the primary symptoms of the disorder. Thus, we see it as vital that a multi-modal approach to treatment be employed. This includes a variety of treatment components provided by the PCT and a close collaboration with the excellent clinical resources within our Medical Center's Mental Health Service. The objectives of the treatment interventions are to reduce the intensity of symptoms and maximize social and vocational functioning. There is also an emphasis upon coordination of care with the other medical services in the Medical Center to optimize attention to physical problems. Veterans co-morbid for alcohol/substance abuse are referred for evaluation and treatment to the Substance Use PTSD Team (SUPT) or other specialized Substance Abuse treatment programs in the Mental Health Service. The PCT staff provides consultation to the various clinic services throughout the SFVAMC, the Veterans Readjustment Counseling Centers in the San Francisco Bay Area, as well as to agencies and private clinical practitioners in the community at large.

The PCT has developed a tightly designed and coherent structure within which to deliver clinical services. Each stage of the clinical process has a well-developed and visible model to follow. The clinical templates we have created serve to provide continuity of clinical documentation as well as serving as a conceptual framework for understanding the multiple factors that inform the clinical care we provide. For the past 2 1/2 years our program has exclusively used an electronic medical record. This has greatly facilitated the coordination of care within our program and with the other clinical services at the Medical Center.

The PCT is organized to provide five stages of treatment to veterans with PTSD: 1) evaluation, 2) stabilization, 3) exposure, 4) integration and relapse prevention and 5) maintenance. Intake screening is done by the PCT Social Worker and the Mental Health Access Center. Evaluations are conducted by all members of the PCT staff and professionals in training with the PCT. All veterans admitted to the PCT have a standardized demographic form completed and sent to the Northeast Program Evaluation Center at the West Haven VA Medical Center. Upon completion of a comprehensive evaluation a treatment plan is formulated. The treatment plan is discussed in the weekly PCT clinical conference. Each patient is assigned a case coordinator and to the stage of treatment most appropriate to his/her needs. Professionals in training with the PCT are supervised by a staff member in all aspects of the cases they treat. The staff member signs off on all the trainee's documentation of formulation and treatment planning. The case coordinator develops a Psychiatry Care Plan, which includes a formulation of the case and a treatment plan listed by identified problems. This document is placed in the patient's record and is updated every three to twelve months depending upon target goals of treatment. The case coordinator, in consultation with the patient, decides when a change in treatment stage is indicated. This decision is reviewed by the PCT at the weekly clinical/administrative meeting. Complex and problematic cases are routinely discussed at the same meeting. The Director of the PCT supervises the day to day clinical activities of the PCT.

Treatment Modalities

Group Therapy: Groups are available to provide treatment interventions at each stage of treatment. The groups include: 1) PTSD education group (4-12 weeks) provides information about PTSD and its consequences, stresses appropriateness for group therapy and prepares the veteran for group treatment, 2) trauma focus groups (6 to 12 months) - exposure therapy in a group context, 3) integration and relapse prevention groups (1 to 2 years) draw from the experience of the trauma focus work and examine it in the context of present day coping style and skills. The objective is to solidify gains in symptom reduction from exposure treatment and emphasize optimal psychosocial functioning, 4) maintenance groups (duration indefinite) provide support, structure and reinforcement of skills learned in prior stages of treatment. Maintenance groups are for the more seriously impaired veterans, 5) ex-prisoner of war groups. These are groups designed to address the special needs of veterans who were prisoners of war. There are separate groups for European and Asian Theater WW II ex-POWs. Currently, groups for all stages of treatment are homogeneous for the wartime era and the level of ego strength of the members.

Individual Therapy: The PCT provides brief individual therapy, when indicated. Individual therapy may be provided: 1) to stabilize a patient in crisis, 2) prepare a patient for group therapy, 3) provide exposure and/or behavioral therapy when group therapy is not appropriate and 4) provide adjunctive therapy to group work when the task of the group does not fit with specific issues of a patient. Most individual treatments are six months or less in duration.

Family Therapy: Family therapy is provided by PCT staff and trainees. Family therapy is available to any veteran in the PCT. The interventions can take the form of consultations or can extend for up to six months of weekly sessions. At times family therapy is concurrent with the earlier stages of treatment if there is an urgent need. In most instances family therapy is conducted in the integration stage of treatment.

Psychopharmacology Clinic: The PCT has a specialized Pharmacology Clinic staffed by all of the PCT psychiatrists. Patients are referred to the Pharmacology clinic by clinicians in the PCT and from clinicians in the community, such as the Veterans Readjustment Counseling Centers. The clinic provides a review of medical status and often serves as a primary referring source to other medical clinics in the Medical Center. The Pharmacology Clinic is available to veterans in the PCT during any stage of the treatment process. Duration of treatment is determined by the presenting symptoms. Case management based maintenance treatment is often a component of long term medication treatment.

Primary Care Clinic: This past year the PCT established a program for providing primary medical care for a select group of veterans. We identified all veterans in our program that were not already in primary care in the Medical Center. They were enrolled in our primary care clinic unless they had chronic medical problems severe enough to require a medical specialist's attention. The emphasis is upon preventive care and coordination of care. Each veteran is assigned one of the psychiatrists in the PCT as his/her primary care physician. The Nurse Clinician with the PCT conducts a yearly preventive health screening on each veteran enrolled in our clinic. The format is modeled after the preventive health screening format used in Primary Care Clinics in the Medical Center. The primary care physician reviews the results from this examination with the patient.

Appendix H

Substance Abuse Programs Description

Overview:
The Substance Abuse Programs are located within the Mental Health Service. Clinical services are organized into three distinct areas: triage acute services, a day hospital, and a large outpatient clinic that incorporates three specialized treatment teams. Triage offers same-day service for walk-in veteran applicants. The Substance Abuse Day Hospital (SADH) provides intensive outpatient care for patients who require additional stabilization and diagnostic evaluation. The Substance Abuse Outpatient Clinic consists of the Drug and Alcohol Treatment Team (DAT), the Opioid Replacement Team (ORT), and the Substance Abuse and Posttraumatic Stress Disorder Team (SUPT). The treatment teams are organized in keeping with a phase model of recovery that differentiates early abstinence issues from later recovery issues.

The Substance Abuse Programs and the Mental Health Service are closely affiliated with the UCSF Department of Psychiatry. Each year substance abuse faculty train and supervise psychology interns, post-doctoral research fellows, social work and nursing trainees, and minority undergraduates who are planning to pursue graduate degrees in psychology. All sixteen PGY-2 residents from the Department of Psychiatry have part-time rotations in one of the treatment teams. Faculty also train and supervise 1-3 substance abuse physician fellows in our VA sponsored fellowship program.

The Substance Abuse Programs are also affiliated with the San Francisco Treatment Research Center (TRC). The TRC sponsors multiple research trials at the VA site, including research on opioid replacement methods, promising new medications to reduce substance abuse, studies of anger management methodologies, and the environments of addicted patients. VA Cooperative Studies sponsor studies on the use of buprenorphine for heroin replacement and the use of naltrexone for alcohol relapse prevention. VA Merit Review Studies sponsor another study on an anger management and cocaine dependence clinical trial.

Triage: Acute Services Program:
The Triage Clinic is a daily walk-in clinic located in Central Access that provides initial assessment, screening, and treatment planning services to all veterans seeking addictions treatment. All eligible veterans are seen on the same day that they present themselves for treatment. Some patients are in withdrawal, or have urgent medical or psychiatric needs, and are also seen by a physician for acute medical or psychiatric intervention. Homeless patients are placed in a shelter in the community and are scheduled to enter the SADH as soon as possible. Other patients who are especially unstable are also enrolled in the SADH for intensive outpatient treatment. Other patients are referred directly to one of the specialized treatment teams in the Substance Abuse Outpatient Clinic.

Substance Abuse Day Hospital (SADH):
The SADH is an intensive outpatient treatment program whose mission is to provide short-term, cost-effective care as an alternative to inpatient hospitalization. It is used to stabilize patients who are unable to initiate abstinence in the less intensive outpatient setting. Some of these patients have serious medical or psychiatric disorders that make it very difficult for them to accomplish even a single day of abstinence. The SADH is also used to intensify structure for patients in outpatient treatment who relapse and cannot reestablish abstinence in the less intensive outpatient setting. The SADH has 24 slots and the average length of stay is 14 days.

Substance Abuse Outpatient Clinic (SAOP):
The SAOP Clinic consists of three specialized treatment teams:

a. The Drug and Alcohol Treatment Team (DAT)
   Treatment in the DAT Team is abstinence oriented and is focused on patients with alcohol, cocaine, and polysubstance abuse problems. Psychosocial treatment is structured by a Phase Model (described below) but also includes other treatments based on an integrative review of multiple assessments. The following treatments are offered:

Phase Model Groups	Anger Management
Specialized Dual Diagnosis Groups	Patient Education

Individual and family counseling Psychopharmacology
Smoking Cessation

b. Opioid Replacement Team (ORT):
The ORT Team primarily treats heroin addicts with opioid replacement medications (methadone and LAAM). Some patients enter research protocols involving methadone or buprenorphine. In addition, all patients are involved in psychosocial treatment based on the Phase Model organized around levels of privileges and frequency of take-out doses. The Clinic also offers adjunctive therapies similar to those offered on the DAT Team.

c. Substance Abuse and Posttraumatic Stress Disorder Team (SUPT):
The SUPT Team treats patients who have substance abuse disorders and PTSD related to military combat experience. Treatment for substance abuse is based on the Phase Model and seeks to stabilize addictive problems prior to working with traumatic material. Treatment for PTSD includes psychopharmacological assessment as well as psychosocial treatment. Often, the initial phases of care last much longer than for single diagnosis patients because of the interaction of the trauma related dual illness.

Treatment Model:
Substance Abuse treatment is based on a Phase Model, developed by Dr. Peter Banys, Director of Substance Abuse Programs, and incorporates a biopsychosocial model of addictive behaviors. This model is integrative and accommodates a longitudinal and developmental framework. It encourages staff members to consider physiological, psychological, and sociocultural factors from each of these domains in the assessment, case conceptualization, treatment planning, and therapy processes. Such an approach contributes to a greater individualization of the treatment process.

The Phase Model described below refers to the names of phases used in alcohol treatment, but the descriptions summarize the basic principles that are implemented in different ways by each of our clinics and treatment teams.

Phase 0: Crisis
In the crisis phase, patients receive a thorough assessment of their substance abuse disorder and their medical and psychiatric problems. The goal of this phase is to stabilize the patient so that he or she may enter into outpatient treatment on one of the treatment teams.

Phase 1: Abstinence
During the abstinence phase, patients learn how to identify the high-risk areas (triggers and cues) that put them at risk for relapse. They also develop adaptive coping strategies for dealing with these high-risk areas. At the same time, patients attend a required number of treatment and education activities. The following tasks are accomplished during the abstinence phase of treatment:

1. achieve 90 days of abstinence
2. attend 24 recovery support groups
3. attend 10 education and recovery classes
4. attend 36 self-help meetings (e.g. Alcoholics Anonymous)

The progression from one phase to the next depends on the completion of behavioral tasks and not merely on the passage of time. The target date for completion of the abstinence phase is 3-6 months from the time of entry into treatment. Patients who relapse, of course, remain in this early phase of care for even more extended periods of time. The minimum successful treatment episode is considered to be graduation from the abstinence phase of the program.

Phase 2: Sobriety
In the sobriety phase, patients require less structure and intensity in treatment. Treatment focuses on the development of adaptive interpersonal skills that have been damaged or destroyed as a result of their substance abuse disorder. Assessments aimed at returning the patient to a productive lifestyle, which may include work or school, may be indicated. Patients are required to attend 48 support or psychotherapy groups.

Phase 3: Recovery

Upon completion of the abstinence and sobriety phases, some patients elect to enter the recovery phase of treatment. Treatment in this phase consists of once a week supportive or psychodynamic group therapy. Treatment is interpersonally oriented and differs little from traditional group and individual psychotherapy. There is a recurrent focus, however, on abstinence and on the use of recovery resources such as community based self-help meetings.

Appendix I

Current SFVAMC PTSD and Substance Abuse Research

Over the past ten years, the PTSD Program has developed a research program, recognized as one of the leading centers in the nation. Its emphasis of inquiry is upon understanding the mechanisms, risks, resiliency and optimal treatments for PTSD. The PTSD staff's original publications are prolific and varied. Dr. Marmar's elucidation of the role of dissociation, at the time of a traumatic event, as a predictor of subsequent prevalence and severity of PTSD is a seminal contribution. Drs. Marmar and Weiss were co-principal investigators on the National Vietnam Veterans Readjustment Study. This study remains the most important prevalence study of combat-related PTSD. Its findings persuaded the Department of Veterans Affairs to develop a nationwide initiative to provide specialized outpatient treatment for Vietnam veterans. The PTSD Program's research team is conducting a series of studies examining the nature of acute stress response in emergency services personnel and police officers. This body of work will lead to an examination of risk factors for acquiring PTSD and resiliency in preventing it. Closely linked to this effort is our inquiry into neurobiologic mechanisms of PTSD, including studies of sleep, neuroendocrine changes, sensory gating, event-related potential and neuroanatomic changes. We have placed a strong emphasis upon the clinical application of the findings from the above research effort. Members of our staff and research team are important contributors to the development of a manualized form of trauma focused group therapy. This treatment approach for PTSD is being tested in a national multi-site VA cooperative study (CSP 420), the largest study of its kind for PTSD ever undertaken. A measure of the quality of the PTSD Program's scientific work is the recognition we have received through funding support. The VA Sierra Pacific Network was awarded a Mental Illness Research, Education and Clinical Center (MIRECC) in November 1998. This is one of six such funded centers nationwide. Our PTSD Program research staff designed the scientific component of the PTSD core of the MIRECC. What follows is a listing of the current grant support for our research effort:

Project Award	Source of Funding/Duration	Amount $
Posttraumatic Stress in Police Officers	National Institute of Mental Health 1997-00	1,674,629
PTSD Core: Sierra Pacific VISN 21 Mental Illness Research, Education and Clinical Center	Department of Veterans Affairs 1998-99	328,516
Biological Studies of Post-Traumatic Stress Disorder	Solvay Pharmaceuticals 1997-99	440,000
MRI and 1H MRSI of Post-Traumatic Stress Disorder	Veterans Administration 1998-01	399,300
Group Psychotherapy Treatment For Posttraumatic Stress Disorder	Veterans Administration, Dept. of Medicine & Surgery Cooperative Studies 420 1996-99	343,784
Electrophysiological Abnormalities in PTSD	Veterans Administration 1997-02	491,800
Sleep and Arousal Disturbances In PTSD	National Institutes of Health 1998-02	431,928

Existing Substance Abuse Research Protocols

Title	Dates	Investigators	Sponsor	Funding
Naltrexone for the Treatment of Alcoholism	1997-00	Banys, Peter	VA CSP #425	$46,000/yr
Drug Abuse Treatment Research and Statistical Analysis Statistical Analysis of Drug Abuse Treatment Research	1994-99	Delucchi, Kevin	NIDA Center	185,997
Drug Abuse Treatment/Services Research Training (Fellowship)	1991-01	Hall, Sharon M.	NIDA	318,042
Research Center for Outpatient Treatments of Drug Abuse, 1P50 DA09253-05	1994-99	Hall, Sharon M. et al.	NIDA Center	4,751,738
Maintaining Nonsmoking, RO1 DA02538-16	1996-01	Hall, Sharon M.	NIDA	328,832
Anger Management in Addicted Veterans	1997-00	Reilly, Patrick	NIDA Center	Incl.
Cocaine Abuse: Anger Management Group Therapy	1997-00	Reilly, Patrick Hall, Sharon, M.	VA Merit	80,000
Bupropion for Smoking Cessation	1998-01	Simon, Joel Carmody, Timothy	TRDRP	$171,276/yr
Transdermal Nicotine Replacement for Hospitalized Smokers	1997-00	Simon, Joel Carmody, Timothy	TRDRP	$153,567/yr
Multicenter Efficacy/Safety Trial of Buprenorphine-Naloxone	1996-99	Tusel, Donald	VA/NIDA	137,680/yr
Selegiline in the Treatment of Cocaine Dependence	1999	Tusel, Donald	VA/NIDA	113,000
Assessing Environments of Opioid and Cocaine Users	1995-99	Wasserman, David	NIDA	162,891

Dates: Application Deadline: January 28, 2005 Start Date: September 1, 2005

Only Typed Applications Accepted

APPLICATION

San Francisco Department of Veterans Affairs Medical Center
Post-Doctoral Psychology Fellowship – Emphasis in Substance Abuse and Posttraumatic Stress Disorders

Identifying Information

Name _____ U.S. Citizen?_____

Mailing Address _____

_____

Home Address _____

_____

Work Telephone ( )_____ Home Telephone ( )_____

*Doctoral Program*_____

Program APA-approved?_____ Program Type (circle): Clinical/Counseling? University/Professional?

Doctoral Degree (circle) Psy.D./Ph.D. Completed?_____

If Answer to Above is "No", please use a separate sheet to specify the following:
Describe in detail the status of your dissertation.
Date on which you expect to compete all requirements for the doctoral degree.
Include a letter from your dissertation chairperson describing your dissertation status and timeline.

*Pre-Doctoral Internship Completed (date)*_____

Pre-Doctoral Internship_____

Internship APA-approved?_____

Post-Doctoral Experience(s) (if any, list)

_____

_____

_____

Application Checklist (Please make sure you have completed all parts below)

_____Completion of parts I, II, III and IV of Application (attached)

_____A copy of your pre-doctoral internship certificate, or letter from current Internship Training Director indicating that you are in good standing to successfully complete your predoctoral internship, including completion date

_____Three letters of recommendation sent to support your application, including a letter of support from your Internship Training Director

_____(If you have not completed doctoral degree) Letter from your dissertation chairperson describing your dissertation status and time line

_____Current CV

_____Graduate Transcript

_____Three self-addressed mailing labels

Use up to one typewritten page to answer each of the following:

I. Please describe your clinical experience and interest with substance abuse and trauma populations respectively, including types of patients, types of clinical activities performed, and types of supervision obtained. Include a brief outline and description of your pre-doctoral internship experience, including major rotations.

II. Please describe any relevant research activities, publications, or other scholarly activity.

III. What is your understanding of ways that trauma (Trauma fellow applicants answers this) and substance abuse (Addiction fellow applicants answers this) affect the psyche?

IV. Please discuss your goals for the fellowship. This should include your specific interests, deficiencies in past training, career goals, and reasons why you would be a good "fit" for this fellowship program. Please indicate whether you would prefer to be considered first for the fellowship position featuring a year-long rotation on the Posttraumatic Stress Clinical Team (Trauma Emphasis) or one of the Substance Abuse Teams (Addiction Emphasis). It is perfectly acceptable to ask to be considered for both positions, but please express any preference you have.

Interviews will be arranged for top candidates based upon a review of the written application materials. In general, in-person interviews will be required; however phone interviews may be made available in the event of special circumstances. Please call us to advise of any problems or special considerations relating to your availability for an in-person interview.

Mail Application Materials to:
Russell Lemle, Ph.D.
Director of Psychology Training and Chief Psychologist
Mental Health Services (116B)
San Francisco DVAMC
4150 Clement Street
San Francisco, CA 94121

Fax #: (415) 750-6987/ (415) 750-6615

Phone calls should be directed to Mrs. Gloria Patel, our program assistant, at (415) 750-2004 for information about your application. For further information about the fellowship call Dr. Lemle at (415) 221-4810 ext. 2348. Dr. Lemle's e-mail: russell.lemle@med.va.gov